Medicaid Quality Strategy: Opportunities to Further Align Managed Care and DSRIP

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Overview

- US Population Health
- What is an External Quality Review Organization (EQRO)?
- DSRIP and Medicaid Performance Improvement Projects (PIPs)
- Potentially Preventable Events (PPEs)
  - What are they?
  - What are the results in Medicaid for Calendar Year (CY) 2014
- Who are the super-utilizers?
- Next steps

The Price Paid for Not Preventing Disease

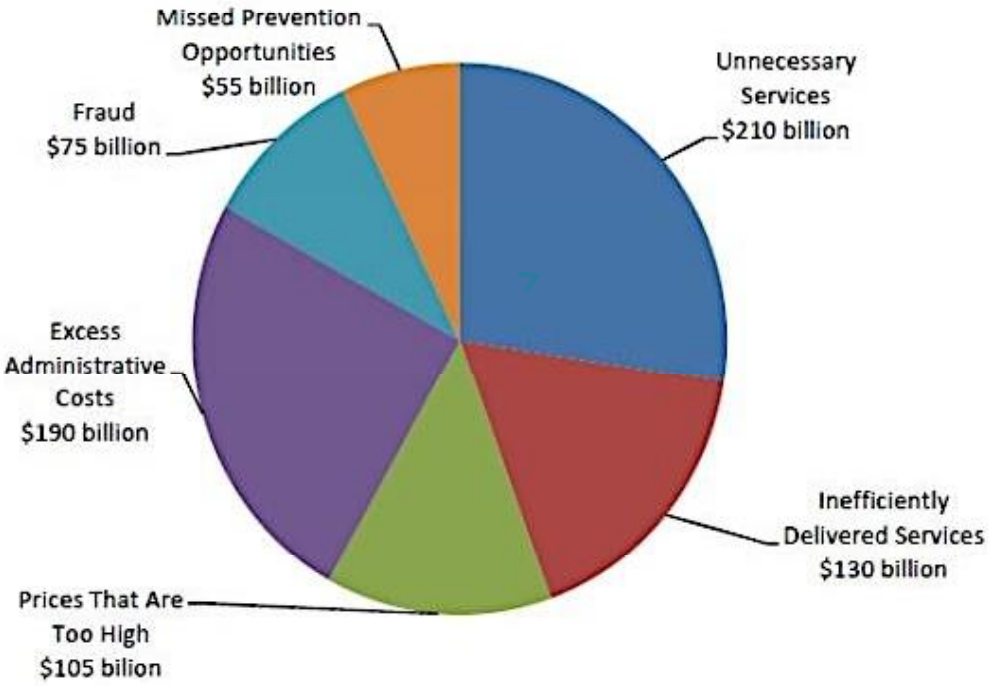
- Between 2005 and 2030 the number of individuals with chronic disease is expected to increase from 133M to 171M.
- 38% of all deaths in the US are attributable to: smoking, unhealthy diet, physical activity, & problem drinking.
- Intensive lifestyle changes can be effective – ex. In diabetes, reduced cost by $44 PMPM.
- 75% of US health spending (total of $2.6 trillion in 2010) is for chronic illness.

Institute of Medicine 2010

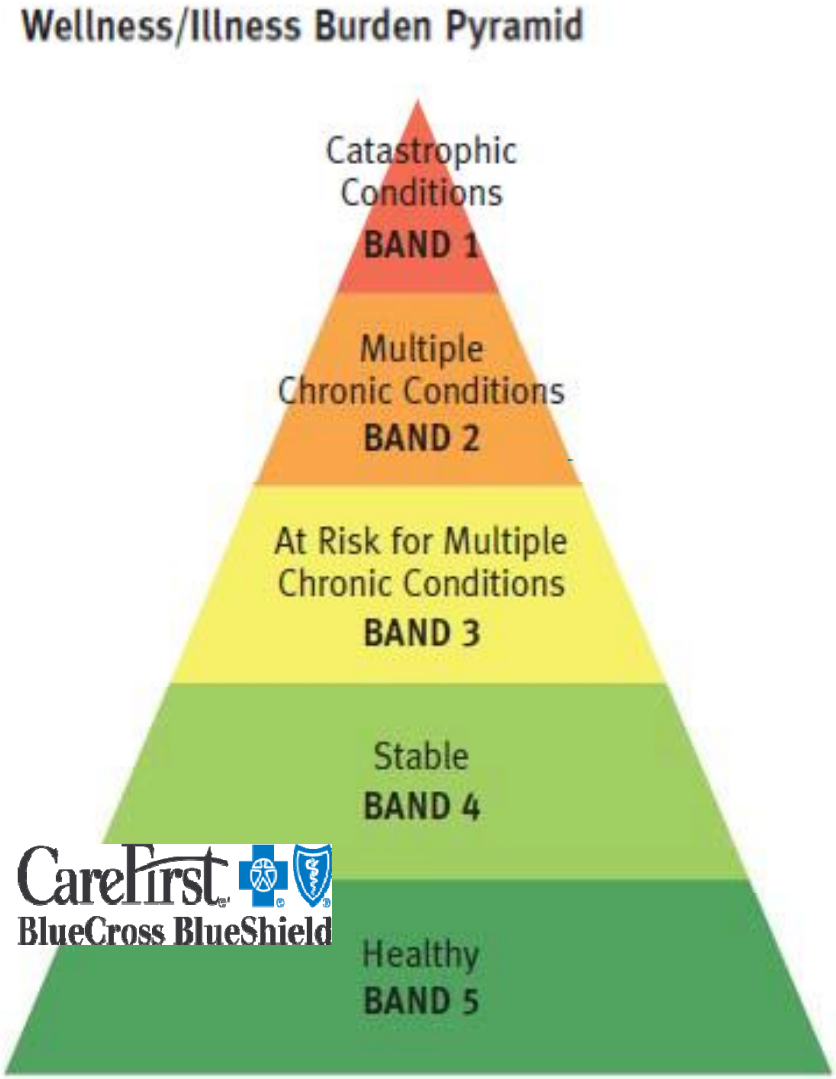
BEST CARE AT LOWER COST

The Path to Continuously Learning Health Care in America

Institute of Medicine Study Released September 2012



Commercial Data But Same Pattern Seen in Medicaid



	Percent of Population	Percent of Cost
Illness Burden < 467 Extremely heavy health care users with significant costs. likely are already in care management.	2%	32%
Illness Burden 148-466 Heavy users of health care system. Costs are well above average and at risk for more extreme costs in the future if not managed closely.	8%	28%
Illness Burden 46-147 Fairly heavy users of health care system, conditions not yet very severe. At risk for becoming high cost if not managed properly.	20%	24%
Illness Burden 14-45 Generally healthy, with light use of health care services. Not likely to become high cost, but beneficial; to monitor in the long term.	20%	10%
Illness Burden 0-13 Generally healthy, often not using health system. Interventions should ensure preventative care guideline adherence.	50%	6%

CareFirst BlueCross BlueShield

IOM Recommendations 2012

- Improve capacity to capture clinical, care delivery process, and financial data
- Accelerate creation and adoption of decision support tools
- Improve coordination within and across organizations
- Increase transparency and health care system performance, including quality, prices, and costs

Texas Senate Bill 7 - 83rd Legislature

- Sec. 536.003 requires HHSC to develop quality-based outcome and process measures used in quality-based payments for acute and long-term care services across all child health plan and Medicaid program delivery models and payment systems.

- **Measures addressing potentially preventable events (PPEs) must be considered.**

- The measures can be aligned with the Centers for Medicare and Medicaid Services (CMS), the Agency for Healthcare Research and Quality (AHRQ), or other federal agency requirements.

What is the External Quality Review Organization?

EQRO and QI are Federal Requirements

MEDICAID

Balanced Budget Act of 1997 (BBA)

- Requires State Medicaid agencies to develop a State quality assessment and improvement strategy
- Requires independent, external reviews of the quality and timeliness of, and access to, care and services provided to Medicaid beneficiaries by Medicaid MCOs and prepaid inpatient health plans

CHIP

Reauthorization Act of 2009

- Requires CHIP managed care plans to participate in external quality review
- Requires each State to annually report on its child health quality measures and other State-specific information collected through EQROs

Enrollee Characteristics
Age, Race/Ethnicity, Health Status , Gender, Health Literacy, Self-Efficacy

Environmental Characteristics
Poverty, Urban/Rural, Health Care Provider Shortage Areas

Structure
- Health Care Delivery System
- Health Plan Organization
- Practice Characteristics
- Disease Management

Outcomes
- Improved Patient Reported Outcomes
- Improved Clinical Indicators
- Reduction in Potentially Preventable Events
- Better Adherence to Treatment Recommendations

Processes
- Evidenced-Based Care
- Individualized Service Plans
- Risk Assessments
- Care Coordinators

Health and Human Services Commission

Assessment of MCO Compliance and Quality

- MCO compliance with state and federal requirements
  - Administrator Interview Tool
- Performance Measurement
  - Electronic Data Validation, Surveys, Quality of Care Measures
- Performance Improvement
  - PIPs and PIP implementations
- Special studies/focused studies
  - Super-utilizers

Performance Improvement Projects
PIPs

PIPs and Federal Regulations

BBA 1997 requires all states with Medicaid managed care to ensure MCOs conduct PIPs (per 42 CFR 438.240)

Projects must be designed to achieve, through ongoing measurements and interventions, significant improvement, sustained over time, in clinical care and nonclinical care areas that have a favorable effect on health outcomes and enrollee satisfaction.

Key Questions for Developing a PIP

- What is the problem and who is affected?
- What causes the problem?
- How will the health plan address the root causes of the problem?
- How will you know if the intervention worked?
- What will you do if it works? If it doesn't?

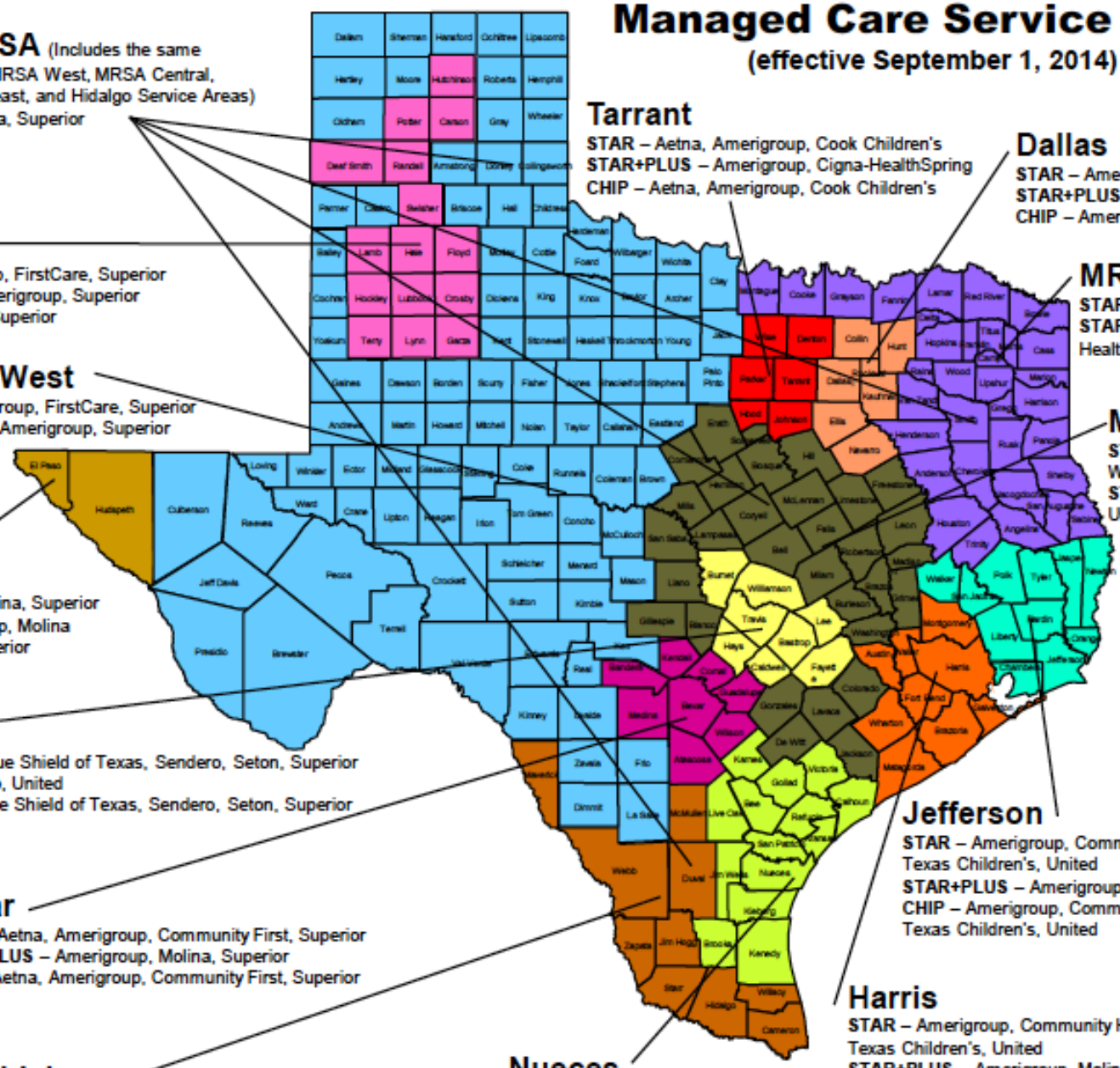
Components of a PIP

1. Select the study topic
2. Define the study questions
3. Select study indicators
4. Use a representative and generalizable study population
5. Use sound sampling techniques (if sampling)
6. Collect reliable and valid data
7. Implement interventions and improvement strategies
8. Analyze data and interpret study results
9. Plan for real improvement
10. Achieve sustained improvement

Possibilities to Align DSRIP and PIPs

Managed Care Service Areas

(effective September 1, 2014)



CHIP RSA (Includes the same counties as MRSA West, MRSA Central, MRSA Northeast, and Hidalgo Service Areas)

CHIP – Molina, Superior

Lubbock

STAR – Amerigroup, FirstCare, Superior
STAR+PLUS – Amerigroup, Superior
CHIP – FirstCare, Superior

MRSA – West

STAR – Amerigroup, FirstCare, Superior
STAR+PLUS – Amerigroup, Superior

El Paso

STAR – El Paso First, Molina, Superior
STAR+PLUS – Amerigroup, Molina
CHIP – El Paso First, Superior

Travis

STAR – Blue Cross and Blue Shield of Texas, Sendero, Seton, Superior
STAR+PLUS – Amerigroup, United
CHIP – Blue Cross and Blue Shield of Texas, Sendero, Seton, Superior

Bexar

STAR – Aetna, Amerigroup, Community First, Superior
STAR+PLUS – Amerigroup, Molina, Superior
CHIP – Aetna, Amerigroup, Community First, Superior

Hidalgo

STAR – Driscoll, Molina, Superior, United
STAR+PLUS – Cigna-HealthSpring, Molina, Superior

Tarrant

STAR – Aetna, Amerigroup, Cook Children's
STAR+PLUS – Amerigroup, Cigna-HealthSpring
CHIP – Aetna, Amerigroup, Cook Children's

Dallas

STAR – Amerigroup, Molina, Parkland
STAR+PLUS – Molina, Superior
CHIP – Amerigroup, Molina, Parkland

MRSA – Northeast

STAR – Amerigroup, Superior
STAR+PLUS – Cigna-HealthSpring, United

MRSA – Central

STAR – Amerigroup, Scott & White, Superior
STAR+PLUS – Superior, United

Jefferson

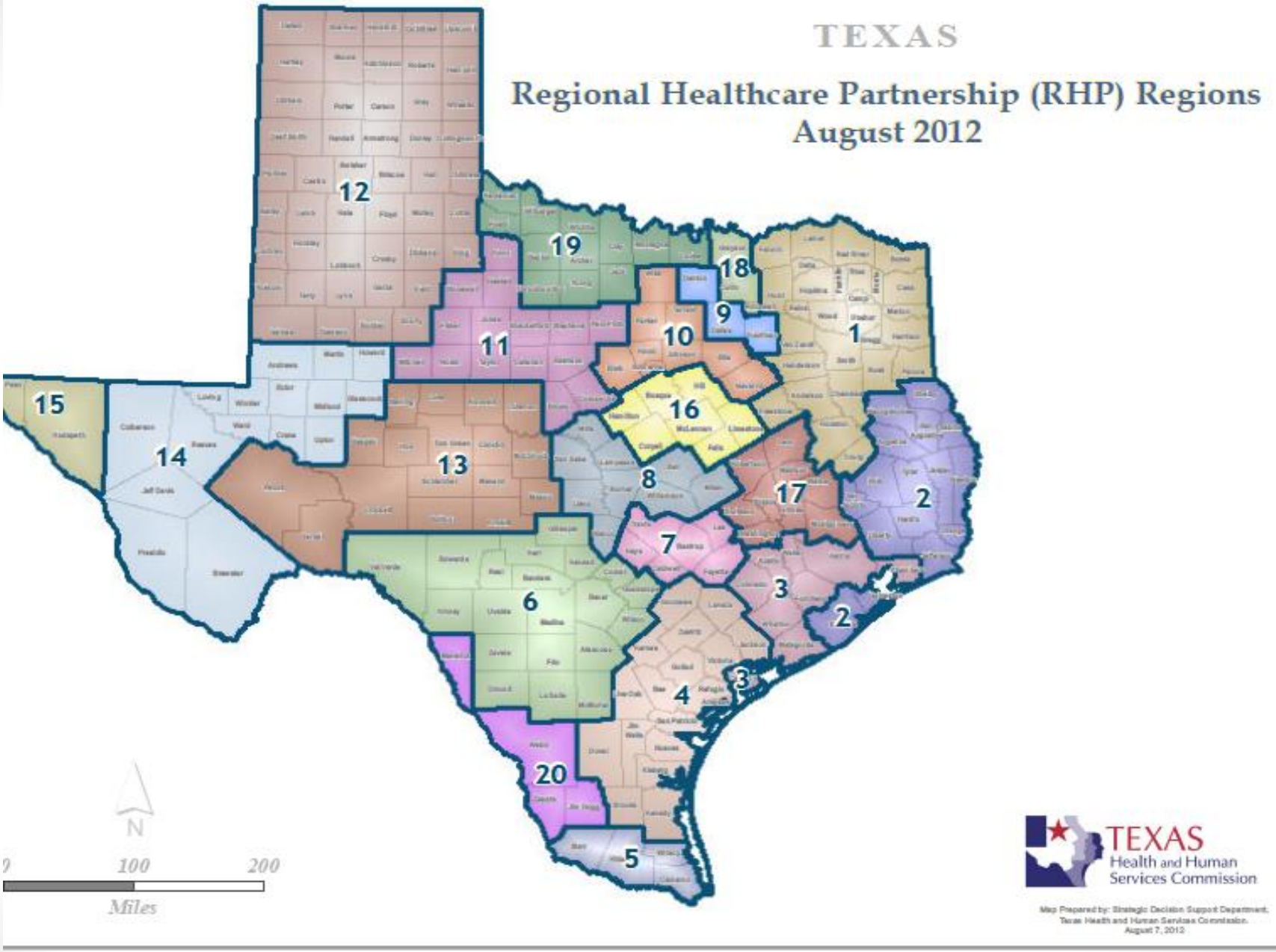
STAR – Amerigroup, Community Health Choice, Molina, Texas Children's, United
STAR+PLUS – Amerigroup, Molina, United
CHIP – Amerigroup, Community Health Choice, Molina, Texas Children's, United

Harris

STAR – Amerigroup, Community Health Choice, Molina, Texas Children's, United
STAR+PLUS – Amerigroup, Molina, United
CHIP – Amerigroup, Community Health Choice, Molina, Texas Children's, United

Nueces

STAR – Christus, Driscoll, Superior
STAR+PLUS – Superior, United
CHIP – Christus, Driscoll, Superior


TEXAS
Regional Healthcare Partnership (RHP) Regions
August 2012
12
19
18
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17
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Miles
TEXAS
Health and Human
Services Commission
Map Prepared by: Strategic Decision Support Department,
Texas Health and Human Services Commission
August 7, 2012

Summary of PIPs Aligned with DSRIP Initiatives

DSRIP Initiative	MCO	DSRIP RHPs Involved	PIP Topic	PIP Interventions	Key Health Issues Addressed
1.2 Increase training of Primary Care workforce	Amerigroup	1, 2, 3, 4, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19	Controlling High Blood Pressure	Employ Practice Management Consultants to train/education provider office staff and providers	Chronic Conditions
1.8 Increase, expand, and enhance dental services	MCNA Dental	Statewide	Annual Dental Visit - Timeliness of Care	Home visits with children of migrant farmworkers to identify as a migrant farmworker and assist with dental accelerated services	Lack of utilization of care
2.11 Conduct Medication Management	Superior	1-20	Asthma Management	Established partnerships with the providers to conduct provider-initiated member outreach to members identified as not having the appropriate asthma medications. Additionally, members are sent asthma-related educational materials and an asthma action plan and instructed to complete it with their PCP.	Chronic Conditions, Lack of patient education on self-managing their health conditions
2.12 Implement/expand care transitions programs	UnitedHealthcare	1, 2, 3, 4, 5, 6, 7, 8, 16, 17, 18, 19, 20	Reduce PPRs with a focus on COPD	Employ Service Coordinators who work with members discharged from an inpatient stay to provide intensive care and service coordination. The service coordinators will work with the members to identify and schedule a visit with a specialist, identify and address barriers to care, and manage medications, among other services.	Chronic Conditions, Care Transitions, PPRs due to Chronic Conditions
2.17 Establish improvement in care transition from the inpatient setting for individuals with mental health and/or substance abuse disorders	ValueOptions	9, 10, 18	Follow-up after BH Hospitalization	Collaborate with a BH facility to establish a care coordination and discharge planning program	Care coordination

Summary of PIPs Aligned with DSRIP Initiatives

DSRIP Initiative	MCO	DSRIP RHPs Involved	MCO Program	Key Health Issues Addressed
1.8 Increase, expand, and enhance dental services	Driscoll	3, 4, 5, 6, 20	Oral Health Initiative - recruits new providers of the Oral Evaluation and Fluoride Varnish services in the Primary Care office, increasing the number of fluoride varnish applications, and ultimately decreasing the number of dental surgeries in the under 5 year old population	Lack of access to and utilization of needed health care services
1.13 Develop behavioral health crisis stabilization services as alternatives to hospitalization	ValueOptions	9, 10, 18	Mobile Crisis Unit - provides both telephonic and onsite crisis services 24/7/365	High rates of PPEs, specifically hospitalizations

2014 Collaborative PIP Topics

- Adolescent Well Care
- Asthma
- Potentially Preventable Readmissions

Collaborative PIP Partnerships

PROGRAM	SERVICE AREA	HEALTH PLANS		TOPIC
CHIP	HARRIS, JEFFERSON	JEFFERSON	CHC, TCHP	AWC
		HARRIS	CHC, TCHP, MOLINA	
CHIP	TRAVIS	BCBS, SENDERO, SETON		AWC
STAR	DALLAS	AG, PARKLAND		ASTHMA
STAR	HARRIS	AG, CHC, MOLINA, TCHP		ASTHMA
STAR	JEFFERSON	CHC, TCHP		ASTHMA
STAR	NUECES	CHRISTUS, DRISCOLL		ASTHMA
STAR	TRAVIS	BCBS, SENDERO, SETON		ASTHMA
STAR+PLUS	HARRIS, TRAVIS, HIDALGO	HARRIS	UHC, MOLINA	PPR
		TRAVIS	UHC, AG	
		HIDALGO	HS	

Potentially Preventable Events PPEs

PPE Calculations

- Potentially Preventable Admissions (PPAs), Readmissions (PPRs), Emergency Department Visits (PPVs)
- Calculated at the Provider Level
- Calculated for STAR, STAR+PLUS and CHIP
- Will be calculated for RHPs
- Using the 3M™ Population Focused Preventable software and methodology (Core Grouping software 2014.0.1; Population-Focused Preventable Grouper Version 29.0)

PPAs: Definition

- Facility admissions that may have resulted from the lack of adequate access to care or ambulatory care coordination.
- The occurrence of high rates of PPAs may represent a failure of the ambulatory care provided to the patient. In addition to a significant quality problem, excess PPAs result in unnecessary increases in cost.

PPAs: Calculation

- Assignment of APR-DRG to inpatient admissions. Based on the reason for admission, an initial preventable status is set.
- Modification can be made for admissions from nursing or residential care.
- Health status (Clinical Risk Groups), determined from encounter data for the year prior to the measurement year, is used to exclude certain patients from being at risk for PPAs
  - Malignancy
  - Catastrophic conditions
  - Less than 3 months enrollment

PPAs: Calculation

- Relative weights are assigned to each admission at risk for PPA assignment by APR-DRG.
  - Based on resource utilization from Texas Medicaid data.
- High resource PPA weigh more in the PPA rate than lower resource PPA so that a calculated excess in the PPA rate reflects potential waste more accurately.
- PPAs are risk adjusted using the Clinical Risk Groups (CRGs).

Sample Provider Level Report: PPAs

PPA Rates

	Total Admissions at Risk for PPA	Actual Number of PPAs	PPA Rate (weighted)	Expected Number of PPAs	Expected PPA Rate (weighted)	Actual-to-Expected Ratio
Provider Results	6284	950	15.46%	1296.08	19.10%	0.81

PPA Expenditures

	Members with PPAs	Actual PPA Expenditures	Expected PPA Expenditures	Actual-to-Expected Ratio for PPA Expenditures
Provider Results	802	$4,008,854.00	$6,956,080.33	0.58

State-Wide PPA Rate

	State Norm	25th Percentile	50th Percentile	90th Percentile
PPA Rate (weighted)	18.48%	25.79%	19.19%	11.54%

Sample Provider Level Report: PPAs

State-Wide Provider Distributions

	25th Percentile	50th Percentile	90th Percentile
Total Admissions at Risk for PPA	156	416	2,184
Actual Number of PPAs	31.0	77.0	362.0
Members with PPAs	26	65	318

PPA Results by Category

Category	Number of PPAs	PPA Category Rate (weighted) per 1,000 Resource Unit	State Percentile of PPA Rate (weighted) per 1,000 Resource Unit			Fraction of all PPAs	PPA Expenditures	Fraction of PPA Expenditures
			25th	50th	90th			
CHF (Congestive Heart Failure)	34	8.9	17.77	9.65	0.00	3.58%	$234,147.00	5.84%
DM (Diabetes)	65	11.2	14.99	8.26	0.00	6.84%	$264,489.00	6.60%
BH/SA (Behavioral Health or Substance Abuse)	10	1.2	1.16	0.00	0.00	1.05%	$36,399.00	0.91%
COPD (Chronic Obstructive Pulmonary Disease)	71	12.8	25.67	13.15	0.00	7.47%	$333,693.00	8.32%
Adult Asthma	22	2.4	2.46	0.29	0.00	2.32%	$75,724.00	1.89%
Pediatric Asthma	126	10.8	15.14	4.99	0.00	13.26%	$317,617.00	7.92%
CP & CAD (Angina and Coronary Artery Disease)	33	4.9	6.91	3.18	0.00	3.47%	$121,295.00	3.03%
HTN (Hypertension)	8	1.3	1.85	0.00	0.00	0.84%	$38,384.00	0.96%
Cellulitis	124	16.7	24.16	15.53	0.00	13.05%	$401,913.00	10.03%
Bacterial PNA (Respiratory Infection)	129	20.3	53.94	33.19	0.00	13.58%	$467,077.00	11.65%
PE & RF (Pulmonary Edema and Respiratory Failure)	2	0.9	0.00	0.00	0.00	0.21%	$10,663.00	0.27%
Others	326	63.3	86.96	60.77	0.40	34.32%	$1,707,453.00	42.59%

STAR Program PPAs Statewide

- Total admissions at risk: 156,190
- Actual PPAs: 21,553
- PPA expenditures total: $95,502,090
- PPA expenditures per 1,000 member months: $3,586

STAR Top PPA Reasons

753 | BIPOLAR DISORDERS

751 | MAJOR DEPRESSIVE DISORDERS & OTHER/UNSPECIFIED PSYCHOSES

463 | KIDNEY & URINARY TRACT INFECTIONS

420 | DIABETES

383 | CELLULITIS & OTHER BACTERIAL SKIN INFECTIONS

249 | NON-BACTERIAL GASTROENTERITIS, NAUSEA & VOMITING

141 | ASTHMA

139 | OTHER PNEUMONIA

113 | INFECTIONS OF UPPER RESPIRATORY TRACT

053 | SEIZURE

PPRs: Definition

- A PPR is a readmission (return hospitalization within the specified readmission time interval) that is clinically related to the initial hospital admission. “Clinically related” is defined as a requirement that the underlying reason for readmission is related to the reason for the initial admission.

- ***Global PPR exclusions***
  - Certain Malignancies,
  - HIV patients,
  - Palliative care,
  - Discharge status of “left against medical advice”.

PPRs: Severity Adjustment

- Since a hospital PPR rate can be influenced by a hospital's mix of patient types and patient severity of illness during the Initial Admission, PPR rates are adjusted for case mix and severity of illness.
- Higher than expected readmission rates can be an indicator of quality of care problems during the initial hospital stay or with the coordination of care between the inpatient and outpatient setting.

Provider Level PPR Example

PPR Rates

	Total Admissions at Risk for PPR	Actual Number of PPR Chains	PPR Rate	Expected Number of PPR Chains	Expected PPR Rate	Actual-to-Expected Ratio
Provider Results	2802	145	5.17%	177.36	6.33%	0.82

PPR Expenditures

	Members with PPRs	Number of PPR Events	Actual PPR Expenditures	Expected PPR Expenditures	Actual-to-Expected Ratio for PPR Expenditures
Provider Results	132	191	$912,199.16	$1,616,313.99	0.56

State-Wide PPR Rate

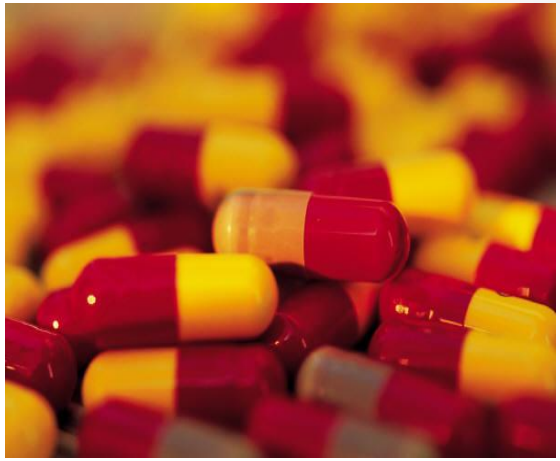
	State Norm	25th Percentile	50th Percentile	90th Percentile
PPR Rate	5.03%	7.14%	4.45%	2.30%

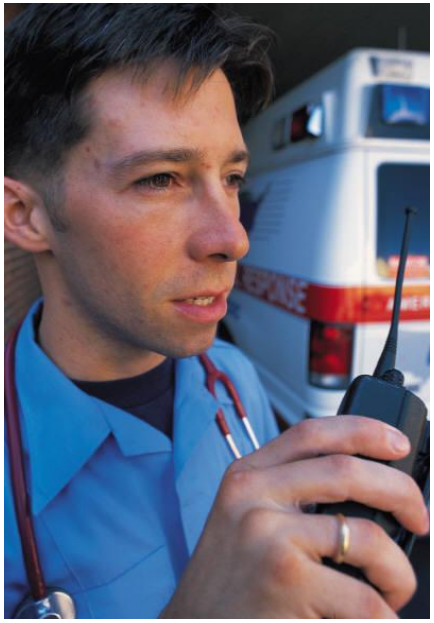
PPR Results by Category

Category	Total Admissions at Risk for PPR	PPR Rate	State Percentiles			PPR Expenditures	Fraction of PPR Expenditures
			25th	50th	90th		
CHF (Congestive Heart Failure)	18	11.11%	21.43%	8.70%	0.00%	$13,720.25	1.50%
DM (Diabetes)	14	21.43%	20.00%	0.00%	0.00%	$29,615.50	3.25%
BH/SA (Behavioral Health or Substance Abuse)	593	10.12%	16.49%	5.75%	0.00%	$358,175.39	39.27%
COPD (Chronic Obstructive Pulmonary Disease)	31	16.13%	17.95%	5.56%	0.00%	$48,203.61	5.28%
CVA (Cerebrovascular Accident)	21	14.29%	10.20%	0.00%	0.00%	$13,260.69	1.45%
Adult Asthma	3	33.33%	0.00%	0.00%	0.00%	$3,081.44	0.34%
Pediatric Asthma	41	7.32%	0.00%	0.00%	0.00%	$6,411.03	0.70%
AMI (Acute Myocardial Infarction)	0	0.00%	0.00%	0.00%	0.00%	$0.00	0.00%
CP & CAD (Angina and Coronary Artery Disease)	14	14.29%	7.69%	0.00%	0.00%	$12,824.16	1.41%
HTN (Hypertension)	13	15.38%	0.00%	0.00%	0.00%	$7,737.08	0.85%
Cellulitis	72	0.00%	7.14%	0.00%	0.00%	$0.00	0.00%
Renal Failure	20	10.00%	14.29%	0.00%	0.00%	$19,074.64	2.09%
C Section (Cesarean delivery)	447	2.24%	1.82%	0.92%	0.00%	$26,301.44	2.88%
Sepsis	10	20.00%	14.29%	0.00%	0.00%	$9,964.60	1.09%
Others	1505	3.32%	4.65%	3.25%	0.00%	$363,829.33	39.88%

STAR Program PPRs Statewide

- Total Readmissions: 306,784
- Readmissions at Risk: 5,629
- PPR expenditures: $45,197,455.20





How are Super-Utilizers Defined?

What does a Medicaid "Super-Utilizer" look like?

Top 10 most frequent ED utilizers in WA State in past 15 months:

1. ED visits in past 15 months range from 78 to 134
2. IP admissions range from 0 to 22 (average of 7)
3. 9 out of 10 have an indication of a current substance abuse problem
4. 10 of 10 have an indication of mental illness
5. 2 of 10 are currently homeless
6. 3 of 10 are currently or have recently been living in a group care setting
7. 1 of 10 is currently receiving in-home personal care

Centers for Medicare and Medicaid Services Super-Utilizer Guidance

- Identifying those with conditions that CMS calls “impactable”, defined as “multiple mental illness or substance use disorders (SUD) and/or multiple preventable admissions for poorly controlled chronic conditions (such as diabetes complications or heart failure exacerbations).”
  - Centers for Medicare and Medicaid Services Informational Bulletin. Targeting Medicaid super-utilizers to decrease costs and improve quality. July 24, 2013.

Current Project

- Texas, Florida, New York Medicaid
- Define super-utilizers using different definitions
  - ED use and expenditures
  - Inpatient use and expenditures
  - Pharmacy
  - Mode of transportation to ED
- Include
  - Adults
  - Children
- Include all conditions

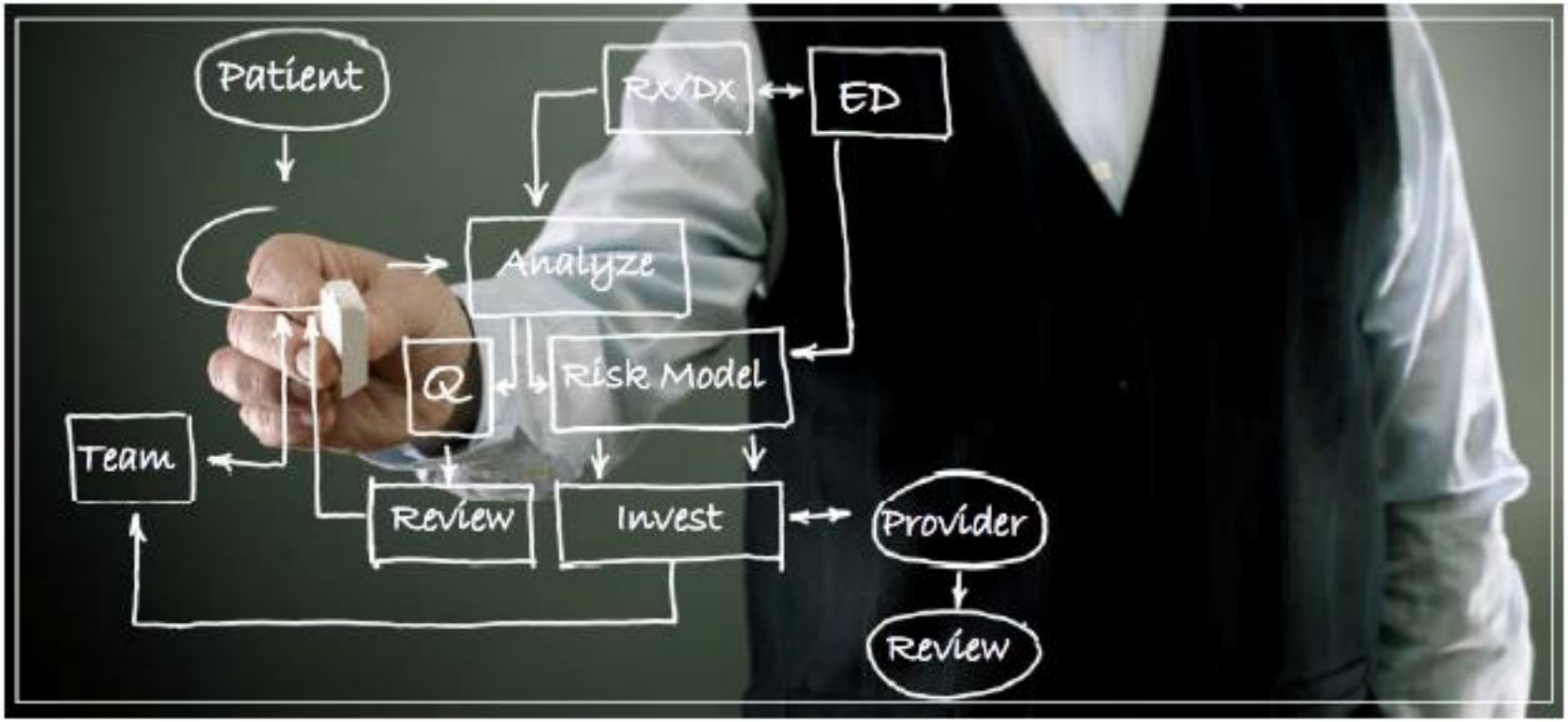
Provider Level Example: Possible Targets Related to Super-Utilizers

PPR Results by Category

Category	Total Admissions at Risk for PPR	PPR Rate	State Percentiles			PPR Expenditures	Fraction of PPR Expenditures
			25th	50th	90th		
CHF (Congestive Heart Failure)	18	11.11%	21.43%	8.70%	0.00%	$13,720.25	1.50%
DM (Diabetes)	14	21.43%	20.00%	0.00%	0.00%	$29,615.50	3.25%
BH/SA (Behavioral Health or Substance Abuse)	593	10.12%	16.49%	5.75%	0.00%	$358,175.39	39.27%
COPD (Chronic Obstructive Pulmonary Disease)	31	16.13%	17.95%	5.56%	0.00%	$48,203.61	5.28%
CVA (Cerebrovascular Accident)	21	14.29%	10.20%	0.00%	0.00%	$13,260.69	1.45%

State Medicaid agency role

- Work collaboratively with plans and providers to build shared commitment to improve outcomes for at-risk patients
- Support multi-system data integration and analytics
- Recognize impact of social and behavioral risk on medical utilization



Questions
and
Thank You